Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West 11th Floor
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 13, 2015	2015_189120_0074	H-002607/2608/2609-15	Follow up

Licensee/Titulaire de permis

GRACE VILLA LIMITED
284 CENTRAL AVENUE LONDON ON N6B 2C8

Long-Term Care Home/Foyer de soins de longue durée

GRACE VILLA NURSING HOME
45 LOCKTON CRESCENT HAMILTON ON L8V 4V5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 23, 2015

A Resident Quality Inspection (2015-323130-0004) was previously conducted February 18-March 6, 2015 at which time Orders #002 and #003 were issued related to bed safety and Order #004 was issued related to housekeeping services. For this follow up inspection, the conditions laid out in Order #003 was addressed and closed and Orders #002 and #004 were not fully met and the Orders have been revised with the remaining requirements.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Environmental Services Supervisor, housekeepers and registered staff.

During the course of the inspection, the inspector toured the home, reviewed the floor cleaning schedules and cleaning procedures, observed 6 residents occupying their beds, reviewed bed safety entrapment audits, clinical assessment forms and residents' plan of care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #003	2015_323130_0004	120

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not ensure that where bed rails were used, that residents were assessed in accordance with prevailing practices, to minimize risk to the resident.

According to prevailing practices tilted "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and endorsed by Health Canada), residents are to be evaluated while sleeping in bed over a period of time by an interdisciplinary team to determine if the bed rail is a safe alternative for the resident after trialling other options (as listed in the guidelines). According to the guidelines, questions would need to be developed and answered related to but not limited to the resident's cognitive state, mobility status, falls history, medication use, toileting habits, sleeping patterns, behaviours, environmental factors and other relevant information that would guide the assessor to make a decision, with either the resident or Power of Attorney (POA), about the necessity for a bed rail. The information would be documented on a form (either electronically or on paper) as to why one or more bed rails are required, what type of rail is required, when the rails are to be applied, how many and on what sides. The interdisciplinary team members involved in the assessment for each resident would include but not be limited to a registered staff member, physiotherapist and personal support worker (PSW), all individuals who would be involved in caring for the resident.

The licensee's bed rail clinical assessment form was reviewed and it was determined that it was not developed in accordance with prevailing practices as identified above and as required as per the previously issued Order #002. The form did not include any

information or questions to guide the assessor as to why the resident needed a rail, how many, on which side, the type of rail and whether alternatives were trialled before coming to a conclusion. No conclusions were noted on any of the forms reviewed. No alternatives trialled were noted on any of the forms reviewed. Only one name or signature was noted on the forms (registered staff). It did not appear that an interdisciplinary team was involved in completing the assessments. According to several registered staff members, an informal process was undertaken whereby PSWs were asked about a particular residents' habits or needs for bed rail use and that was the extent of the interdisciplinary review. The Physiotherapist was interviewed, but was newly employed and was not involved in any team assessments, however each resident was previously assessed by the former Physiotherapist for mobility and the information identified in the residents' care plans.

At the time of inspection, six residents were observed sleeping in bed, each with one or more rails elevated. In order to determine why residents required a bed side rail, the plan of care was reviewed. The resident's plan of care for the six residents reviewed included the reason for bed rail use, but the statement was very generic and was the same statement used for each resident. The statement was "May use 1 or 2 A rails for bed mobility". During a tour of the resident rooms over the lunch period on September 23, 2015, when residents were out of their rooms, approximately 90% of the beds had one or more bed rails elevated. When both the Administrator and Director of Care were asked if bed rail use had been reduced after the assessments were completed, they reported a 75% reduction. It did not appear that there was a 75% reduction in use based on the number of rails observed in the raised position. Discussion was held regarding the reasons for the continuation of keeping bed rails in the raised or "guard" position. Some reasons given related to staff habits, resident preference and POA resistance. Discussion was held regarding the risks of bed rail entrapment, including those beds that have passed all 4 zones of entrapment (all areas between the rail and the mattress) and the importance of a thorough assessment of each resident and subsequent documentation. [s. 15(1)(a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that as part of the organized program of housekeeping under clause 15(1)(a) of the Act, that procedures were implemented for cleaning of the home, specifically flooring material located in resident rooms, tub and shower areas, corridors and common spaces.

The licensee's floor cleaning procedures were developed and updated since the previous visit, however the procedures and schedules developed could not be met. During the previous inspection completed in early March 2015, the flooring material was observed with wear patterns and dark areas under beds and/or around the perimeter of approximately 13 bedrooms and appeared dirty or discoloured in corridors and bathing rooms located on the east side of the home on all 3 floors. During this inspection, improvement was noted in resident bedrooms on the 1st floor, and a slight improvement in all 3 tub rooms on the east side,
however many bedrooms on the 2nd and 3rd floor were either worse or had not changed since the previous visit with the exception of the rooms previously identified in the report. Additional resident rooms were noted to be dirty in appearance (black)in addition to all corridors and around the perimeter of the dining rooms on 2nd and 3rd floors.

According to the Environmental Services Supervisor (ESS), many bedrooms were pending a deep cleaning or stripping and a re-wax and the plan was to get assistance from an external contractor. However, no dates for the arrival of the external contractor could be provided. The flooring was being stripped and re-waxed by existing staff in the home and the process was very slow and time consuming, clearly who were unable to meet the scheduled expectations. [s. 87(2)(a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 16th day of October, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2015_189120_0074
Log No. / Registre no:	H-002607/2608/2609-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 13, 2015
Licensee / Titulaire de permis :	GRACE VILLA LIMITED 284 CENTRAL AVENUE, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	GRACE VILLA NURSING HOME 45 LOCKTON CRESCENT, HAMILTON, ON, L8V-4V5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Annette Spretnall

To GRACE VILLA LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_323130_0004, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall:

1. Develop a clinical bed rail use assessment program (tool/form, policy and process) using information contained in the prevailing practices document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003".

2. Re-assess all residents who use one or more bed side rails by applying the bed rail use assessment program and document accordingly.

3. Update the resident's care plans with the outcome of the re-assessments if necessary.

4. Ensure that all health care staff (Personal Support Workers, Physiotherapist and Registered Staff) are informed about the bed rail use assessment program.

Grounds / Motifs :

1. The licensee did not ensure that where bed rails were used, that residents were assessed in accordance with prevailing practices, to minimize risk to the

resident.

According to prevailing practices tilted "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and endorsed by Health Canada), residents are to be evaluated while sleeping in bed over a period of time by an interdisciplinary team to determine if the bed rail is a safe alternative for the resident after trialling other options (as listed in the guidelines). According to the guidelines, questions would need to be developed and answered related to but not limited to the resident's cognitive state, mobility status, falls history, medication use, toileting habits, sleeping patterns, behaviours, environmental factors and other relevant information that would guide the assessor to make a decision, with either the resident or Power of Attorney (POA), about the necessity for a bed rail. The information would be documented on a form (either electronically or on paper) as to why one or more bed rails are required, what type of rail is required, when the rails are to be applied, how many and on what sides. The interdisciplinary team members involved in the assessment for each resident would include but not be limited to a registered staff member, physiotherapist and personal support worker (PSW), all individuals who would be involved in caring for the resident.

The licensee's bed rail clinical assessment form was reviewed and it was determined that it was not developed in accordance with prevailing practices as identified above and as required as per the previously issued Order #002. The form did not include any information or questions to guide the assessor as to why the resident needed a rail, how many, on which side, the type of rail and whether alternatives were trialled before coming to a conclusion. No conclusions were noted on any of the forms reviewed. No alternatives trialled were noted on any of the forms reviewed. Only one name or signature was noted on the forms (registered staff). It did not appear that an interdisciplinary team was involved in completing the assessments. According to several registered staff members, an informal process was undertaken whereby PSWs were asked about a particular residents' habits or needs for bed rail use and that was the extent of the interdisciplinary review. The Physiotherapist was interviewed, but was newly employed and was not involved in any team assessments, however each resident was previously assessed by the former Physiotherapist for mobility and the information identified in the residents' care plans.

At the time of inspection, six residents were observed sleeping in bed, each with one or more rails elevated. In order to determine why residents required a bed side rail, the plan of care was reviewed. The resident's plan of care for the six residents reviewed included the reason for bed rail use, but the statement was very generic and was the same statement used for each resident. The statement was "May use 1 or 2 A rails for bed mobility". During a tour of the resident rooms over the lunch period on September 23, 2015, when residents were out of their rooms, approximately 90% of the beds had one or more bed rails elevated. When both the Administrator and Director of Care were asked if bed rail use had been reduced after the assessments were completed, they reported a 75% reduction. It did not appear that there was a 75% reduction in use based on the number of rails observed in the raised position. Discussion was held regarding the reasons for the continuation of keeping bed rails in the raised or "guard" position. Some reasons given related to staff habits, resident preference and POA resistance. Discussion was held regarding the risks of bed rail entrapment, including those beds that have passed all 4 zones of entrapment (all areas between the rail and the mattress) and the importance of a thorough assessment of each resident and subsequent documentation. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 15, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_323130_0004, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The licensee shall:

1. Strip and re-wax or deep clean all resident room floors, corridors and dining rooms that have been identified with wear patterns or are black or discoloured. If the flooring material cannot be restored and remains discoloured after stripping, document the location and flooring condition.
2. Develop a routine audit to monitor the sanitation level of all flooring throughout the home and document the condition of the flooring and location.
3. Develop an action plan to address the identified flooring condition on an on-going basis.

Grounds / Motifs :

1. The licensee did not ensure that as part of the organized program of housekeeping under clause 15(1)(a) of the Act, that procedures were implemented for cleaning of the home, specifically flooring material located in resident rooms, tub and shower areas, corridors and common spaces.

The licensee's floor cleaning procedures were developed and updated since the previous visit, however the procedures and schedules developed could not be met. During the previous inspection completed in early March 2015, the flooring material was observed with wear patterns and dark areas under beds and/or around the perimeter of approximately 13 bedrooms and appeared dirty or discoloured in corridors and bathing rooms located on the east side of the home on all 3 floors. During this inspection, improvement was noted in resident bedrooms on the 1st floor, and a slight improvement in all 3 tub rooms on the east side,
however many bedrooms on the 2nd and 3rd floor were either worse or had not changed since the previous visit with the exception of the rooms previously identified in the report. Additional resident rooms were noted to be dirty in appearance (black)in addition to all corridors and around the perimeter of the dining rooms on 2nd and 3rd floors.

According to the Environmental Services Supervisor (ESS), many bedrooms were pending a deep cleaning or stripping and a re-wax and the plan was to get assistance from an external contractor. However, no dates for the arrival of the external contractor could be provided. The flooring was being stripped and re-waxed by existing staff in the home and the process was very slow and time consuming, clearly who were unable to meet the scheduled expectations. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 15, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 13th day of October, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK

Service Area Office /
Bureau régional de services : Hamilton Service Area Office